DISEASES WITHOUT BORDERS:
AN ECONOMIC STRUGGLE?
International Forum hosted by IDRC and CIDA
Montréal, May 8, 2003, at La Conférence de Montréal

MAUREEN O'NEIL-REMARKS FOR THE FORUM

(INTRODUCTORY REMARKS)

Bonjour. J'ai le grand plaisir de vous accueillir à cet important forum sur les maladies sans frontières.

Encore une fois cette année, le CRDI a l'honneur de jouer un rôle prépondérant à la Conférence de Montréal—devenue une tribune de premier plan où se tiennent des débats avant-gardistes sur les grands enjeux mondiaux. Je tiens à remercier nos collègues de l'ACDI, qui ont collaboré avec nous à l'organisation de ce forum. Le CRDI exprime également toute sa gratitude à l'Unité de santé internationale de l'Université de Montréal pour l'aide qu'elle a apportée à l'organisation et à la publicité.

Nous sommes privilégiés d’avoir parmi nous aujourd’hui des personnalités aussi éminentes. Nos conférenciers ont oeuvré au sein de gouvernements, d’organismes de la société civile, du monde des affaires et du milieu universitaire. Leurs parcours ont été très différents—et c’est donc sous des angles fort divers qu’ils aborderont la brûlante question des maladies infectieuses.

Malgré la grande variété de leurs expériences, toutefois, ils ont en commun le profond désir de faire avancer les choses. Nous sommes convaincus que vous tous pourrez, grâce à votre énergie et à votre détermination, nous aider à relever – un jour – l’un des plus grands défis auxquels l’humanité ait jamais été confrontée.

Dans quelques minutes, je vous présenterai notre conférencier d'honneur, l'envoyé spécial du Secrétaire général des Nations Unies pour le VIH-SIDA en Afrique, M. Stephen Lewis. Je suis certaine que vous connaissez tous et toutes ses qualités remarquables : son ardeur au travail… son engagement indéfectible… Nous sommes vraiment honorés qu'il ait accepté notre invitation.

Before Stephen Lewis speaks to us, however, I'd like to provide a little context for today's discussion—to fill in a few conceptual and historical details. These details might help us address the questions of where we are at the moment, … how we got here, … and where we might be headed in the near future. I would like to point out that these issues will also be addressed in a working session this afternoon in this same room after the luncheon. We invite you to stay and participate in this exchange.

We at IDRC believe that the struggle against infectious disease has entered a new phase. Today's announcement by Health Canada and the Canadian Institutes of Health Research of additional funding for global health research reaffirms this assertion. An amount of 2.4 million dollars is now available to teams of researchers from Canada and the South to find practical solutions to global health problems.

We are indeed entering a phase in which novel —and perhaps unlikely— partnerships are becoming possible. But not only are these partnerships possible, they are essential—given the vast scope of the challenge in many countries. In southern Africa, for instance, it is inconceivable that any sector of society could remain sheltered from the impact of AIDS.

This new phase presents us with new creative opportunities … with more nuanced relationships between players… and with a more fluid political and social context. The challenge of this new era—as we see it—is to remain open to the emergence of pragmatic solutions that involve new players … and that are tailored to fit specific local situations. We need to be flexible and to resist fixed, ideological positions.

At the same time, however, we have to be mindful of the longer-term effects of involving new players in health care delivery. Will this process diminish or enhance the capacity of the public health care system? Will it promote or inhibit the equitable distribution of health care resources? More on these questions a little later.

So, we are at a new stage in the process. But what else has happened recently? Well, for one, there has been a renewed worldwide awareness

of the threat posed by infectious diseases. This new awareness has emerged even in countries where infectious disease had not been a dominant public concern.

The reason for this new awareness can be summed up in one little word: SARS. In Canada, this mystery virus has been front-page news for weeks on end.

In the short time it has taken for this term - ‘SARS’ - to enter the medical lexicon, this mystery virus has driven home to people in the developed world the lessons that others have known for a long time. It has reminded Canadians, for instance, how important it is to have a health system with enough reserves to absorb a sudden shock. And it has shown us how inter-dependent all aspects of society are.

In Canada, sadly, SARS has killed 23 people. It has also hurt local economies. It has created huge anxiety. It has strained health care systems. And this in a prosperous, developed country, with a health care system that is the envy of the world. Keep in mind, also, that SARS has a lower mortality rate than many other infectious diseases.

Of course, in the developing world, people don't need a SARS outbreak to remind them of such lessons. In much of southern Africa, for instance, devastating diseases—HIV/AIDS, malaria, tuberculosis—form a constant backdrop to daily life.

What's particularly frustrating is that—unlike SARS—there *are* drugs that can mitigate the effects of those diseases. And there are well-established means of preventing those diseases from spreading.

Yet what has often been lacking is –first—money, and—secondly—institutional capacity. Does a particular country's health system have the capacity to deliver the care to the people who most need it? And if the public health system can't do the job, then who can?

Depuis plusieurs années, ces questions donnent lieu à un débat houleux et passionné.

Cela a commencé dans les années 1980—en pleine période d'ajustement structurel—avec une série de réformes visant à réduire le rôle de l'État et à promouvoir l'entrepreneurship. Le recouvrement des coûts et la privatisation étaient à l'ordre du jour. On a alors assisté à une réduction considérable de la taille des systèmes de santé dans les pays en développement.

Ces dernières années, il y a eu retour du pendule. Nos sociétés ont été frappées de plein fouet par des épidémies comme celle du VIH-SIDA, et il est vite devenu évident que les systèmes de santé publics, après la cure d'amaigrissement qu'ils avaient subie, n'étaient plus adéquats. Aujourd'hui, il est clair que les ressources font cruellement défaut—et que les systèmes de santé publics sont incapables de répondre à une demande aussi considérable.

Que faire? C'est certain, il n'y a guère d'incitations économiques qui pourraient encourager des fournisseurs du secteur privé à offrir des services de santé aux pauvres. De même, il n'est pas réaliste de laisser entendre que les systèmes de santé publics pourraient rapidement être remis à niveau de façon à être en mesure de satisfaire à la demande actuelle. Nous n'avons tout simplement pas les ressources financières pour ce faire.

Il y a aussi une autre possibilité, soit les partenariats entre le secteur public et le secteur privé, que préconisent Jeffrey Sachs et la Commission Macroéconomie et Santé de l'Organisation mondiale de la santé. Mais est-ce bien la voie à suivre? Selon certains, ces partenariats pourraient représenter le meilleur des mondes possibles. D'autres estiment cependant qu'ils pourraient nous entraîner sur une pente dangereuse menant tout droit à la privatisation—et à la destruction des systèmes de santé publics.

But as this debate continues, where are we in practical terms? I believe we have arrived at an interesting nexus--where the private sector has taken on some roles, and activists and public health providers have taken on others. In an ad hoc way, new relationships have developed between

these forces—their work has become complementary. And there is something practical to build on here.

Later today, we'll examine some specific examples of how different social sectors are filling new roles. New partnerships are showing new promise. But there are potential pitfalls to be wary of.

Here we return to some of the questions I posed earlier. Might these innovations diminish the capacity of the public health care system? Might they work against the equitable provision of health services? The challenge here is to make sure that these new players function as collaborators with—and not competitors to—the public health systems. It's essential that they not divert resources or expertise from the public services that remain the only option for the poorest members of society.

This fundamental objective of promoting equity in the delivery of health care, is at the core of a new IDRC program called Governance, Equity and Health.

The program was launched just last year, in 2002. It will initially focus on Sub-Saharan Africa, Latin America and the Caribbean. Priority conditions that the program will address include HIV and Tuberculosis. There are two fundamental goals to the GEH program, but they are intertwined and mutually reinforcing. The first goal is to improve health care—particularly for marginalized and underserved people—by looking at issues of governance. The second goal—perhaps the mirror image of the first—is to use health care as the entry point to improve standards of governance. So it's a two-way street.

At ground level, these general goals splinter off as three practical objectives. The first of those goals is to strengthen health systems by supporting research into how governments can deliver health services equitably and effectively. The second is to promote civic engagement. This means bringing together NGOs, researchers, advocates, health practitioners, and others—to promote citizen participation in health care issues. Finally, the program aims to increase the effectiveness of research in the formulation of health policy.

The idea for the GEH program sprang from the experience of another IDRC-supported program: the Tanzanian Essential Health Interventions Project, or TEHIP. TEHIP is similarly focused on health interventions that have a high value to the poorest communities. One example of this is the distribution of pesticide treated bed nets, which have been proven effective in reducing the spread of malaria. In Tanzania, malaria

accounts for 30 % of life lost due to death and debilitating illness each year.

Promouvoir l'équité dans la prestation des services de santé… Accroître la capacité à long terme des systèmes de santé publics… Ce sont des objectifs que nous ne devons pas perdre de vue tandis que nous cherchons des solutions, dans l'immédiat, pour remédier aux ravages que font des maladies comme le SIDA, le paludisme et la tuberculose.

Tous ces défis, je suis certaine que Stephen Lewis y a beaucoup pensé dans son travail d'envoyé spécial du Secrétaire général des Nations Unies pour le VIH-SIDA. Comme je vous l'ai promis plus tôt, je vous présente maintenant Stephen Lewis.

Stephen became leader of the New Democratic Party of Ontario and—in the mid-1970s—leader of the Official Opposition in that province.

His appointment as Canadian ambassador to the United Nations in 1984 led to a number of international engagements. Stephen Lewis has served as UN special advisor on Africa, as chair of the team investigating the 1994 genocide in Rwanda, and as deputy executive director of UNICEF for three years. He became the UN's special envoy on AIDS in 2001.

Yet those who know him and work with him will say that these distinctions say nothing about the special human qualities that Stephen Lewis possesses.

He is a man who cares deeply about Africa and its people. He is a devoted public servant who puts his heart and soul into his work. He is a

tireless worker whose enthusiasm is matched only by his creativity and his willingness to embrace fresh ideas. And he is a man with an important message.

Please welcome Stephen Lewis…

(INTRODUCTION TO FIRST PANEL AFTER THE PRESENTATION BY MR. LEWIS)

Bienvenue à cette première séance.

Comme vous avez pu le voir dans le programme, elle a pour titre « Forces du marché et impératifs de santé : vrais ou faux amis? »

Permettez-moi de tenter d'expliquer – très brièvement – ce que signifie ce titre. Nous savons tous que le secteur privé est de plus en plus mis à contribution quand il s'agit de maîtriser la propagation de maladies infectieuses comme le VIH-SIDA et d'en atténuer les effets. Les compagnies y contribuent en partie parce que c'est intéressant pour elles sur le plan financier et en partie, également, pour jouer leur rôle de bons citoyens—et de membres à part entière du tissu social. Et quand ces compagnies participent à la prestation des services de santé, leurs interactions avec d'autres intervenants dans la société se font relativement complexes.

En voici un exemple. Il y a, en Afrique australe, une compagnie sucrière du nom de Tungaat-Hulett. Vingt pour cent des employés de cette compagnie vivent avec le VIH-SIDA. La compagnie leur offre maintenant des médicaments antirétroviraux. Et elle n'est pas la seule à agir ainsi. Dans

toute la région, plusieurs petites et moyennes entreprises offrent des médicaments antirétroviraux à leurs employés porteurs du VIH.

In adopting these policies, the companies take their place within a complex web of relationships. For a start, these companies are beneficiaries of the work of the activist community. Were it not for activist groups pushing for lower drug prices, companies could not afford to provide these drugs to their employees.

But these corporate initiatives—in turn—provide some benefit to the public sector and to civil society groups. For example, corporate drug programs remove some of the financial pressure from the public sector. In addition, these programs provide a kind of health-care delivery laboratory. They make it possible to observe how the small-scale pilot projects initiated by NGOs can be scaled-up to serve larger numbers of people.

Those are the positive possibilities.

But there's also a potential downside… and that brings us back to this need to strike a balance between market forces and health imperatives.

In short, we need to make sure that private sector participation does not fragment or diminish the public health system.

Hopefully, we'll be exploring these issues during this session.

But first, I'd like to introduce our two speakers on this morning's panel—both of whom have extensive international experience dealing with infectious diseases.

Our first presenter is Dr. James Orbinski. Dr. Orbinski is currently Research Scientist and Associate Professor of Family and Community Medicine, at St. Michael's Hospital and the Centre for International Health at the University of Toronto. He is also the Saul Rae International Fellow at Massey College and the Munk Centre for International Studies at the University of Toronto.

His current projects include an initiative for the treatment of neglected diseases in the developing world. He's also involved with a project to establish a manufacturing capacity within five African countries – to provide medicines for AIDS, Malaria and TB.

Dr. Orbinski is also past president of Médecins Sans Frontières – and in 1999, he delivered the acceptance speech when MSF was awarded

the Nobel Peace prize. One of his accomplishments as president was to launch the “Access to Essential Medicines Campaign.”

Dr. Orbinski is no stranger to challenging situations. He was the head of mission of MSF in Goma, Zaire, and in Kigali, Rwanda—both during times of crisis.

Dr. Orbinski also has a deep commitment to the welfare of children. He is co-founder of McMaster University’s Health Reach Program, which promotes the health of children in war zones. He is also an advisor to ‘War Child Canada’ and ‘Street Kids International.’

One other thing that's highly relevant to today's topic: Dr. Orbinski is on the boards of three NGOs that focus on helping people suffering from infectious diseases.

Also here to share his insight into the challenges posed by infectious diseases, is Dr. Allan Ronald.

Dr. Ronald is participating in this panel as a Board member of the Academic Alliance for AIDS Care and Prevention in Africa. The AIDS Care Alliance was founded in 2002, after receiving start-up funding from Pfizer Pharmaceuticals.

AIDS Care has trained almost 100 physicians to care for people with HIV. Most of these physicians are from Uganda—although 12 of them are from other African countries. AIDS Care has enrolled 2,000 HIV patients in its clinic--and most of those patients have advanced AIDS. The organization has also begun clinical research and prevention initiatives.

Dr. Ronald's involvement with the AIDS Care alliance stems from his many years of work in Africa. In 1978 he was invited to Kenya to assist in sexually transmitted disease control. At that time, the HIV virus had just arrived in Africa. Dr. Ronald and his Kenyan and Canadian colleagues began a 15-year research program into HIV and AIDS.

In the year 2000, he was invited to Uganda to assist Ugandan and American colleagues, and two years later the AIDS Care Alliance was up and running. Dr. Ronald considers the greatest successes of the Alliance to be the training of doctors in HIV care… and also the demonstration that, with little money, AIDS patients can remain well, and can continue to work and to be able to look after their families.

Please welcome today’ s speakers.

Dr. Orbinski….

(AFTER HIS TALK, TO INVITE DR. RONALD TO SPEAK)

Dr. Ronald…

(AFTER DR. RONALD’S TALK, TO INVITE THE DISCUSSANT, MR. JIM KEON)

Now, to get the discussions flowing, let me turn over to Jim Keon. Mr. Keon is President of the Canadian Generic Pharmaceutical Association…the organization representing Canada’s pharmaceutical industry. Mr. Keon graduated with an M.A. in Economics from

Queen's University, and has extensive experience in areas of intellectual property, trade and consumer protection.

Mr. Keon…

(QUESTIONS AND DISCUSSIONS WILL FOLLOW THE COMMENT OF THE DISCUSSANT. YOU SHOULD INDICATE THAT IF SOME PARTICIPANTS HAVE QUESTIONS FOR MR. LEWIS, THEY SHOULD ASK THEM DURING THIS TIME)

(AFTER THE PERIOD OF DISCUSSION, YOU HAVE TO ANNOUNCE A SHORT COFFEE BREAK OF 10-15 MINUTES)

(INTRODUCTION TO SECOND PANEL AFTER COFEE BREAK)

Welcome back- it's now time for our second panel. The theme of this session takes the form of a question: "How can health systems cope with pandemics?"

As those words imply, we want to get practical here. Earlier this morning we heard a lot about new relationships, new players in the struggle against infectious disease. Now, our focus is more on the state sector. And we want to be specific in the examination of governments' roles. We want to help identify the key bottlenecks that have to be overcome. We want to look for priority areas of research, and hopefully map out some areas that require action.

Our speakers on this panel are very well suited to this task. Both of them are in charge of government health ministries. They have front line experience of the issues we are discussing today: ensuring the effective use of health care budgets; building and sustaining a health care system with the capacity to deal with spread of infectious disease.

Without further delay, I will introduce them to you.

The Honorable Anna Abdallah is an M.P. and Minister for Health in the United Republic of Tanzania. She has held numerous cabinet positions in the Tanzanian government… including Minister for Public Works, Minister for Agriculture and Livestock Development, and Minister for Local Government, Community Development, Co-operatives and Marketing.

Mrs. Abdallah has also served as National Chairperson of the Union of Tanzanian Women since 1994. She has chaired and served on the executive of a number of organizations in Tanzania. She is also a frequent participant in international conferences under the auspices of organizations such as the World Health Organization and the United Nations.

In 1995, Mrs. Abdallah was awarded Order of the United Republic of Tanzania. The honor was conferred by Tanzania's first president, the late Julius Nyerere.

Nous avons également le plaisir d'accueillir le docteur Fernando Cupertino, secrétaire à la Santé de l'État de Goiás, au Brésil.

Le docteur Cupertino a une formation en médecine et en droit. Il a été tour à tour secrétaire municipal à la Santé de la ville de Goiás, directeur général de l'hôpital Saô Pedro D'Alcantara et directeur de la planification et de l'organisation des services de santé de l'État de Goiás.

Toujours au Brésil, il a été membre du Conseil national de la santé et a été élu vice-président –puis président—du Conseil national des secrétaires d'État à la Santé.

Une période de discussion suivra les interventions de nos deux éminents conférenciers.

Ensuite, nous entendrons un invité de marque, le docteur Bernard Kouchner, fondateur de Médecins Sans Frontières.

C’est une tâche très agréable que de leur souhaiter la bienvenue à tous les trois. Voici d’abord nos conférenciers…

Minister Abdallah…

(AFTER HER PRESENTATION, YOU INVITE DR. FERNANDO CUPERTINO TO SPEAK.)

Dr Cupertino…

(AFTER DR CUPERTINO’S PRESENTATION, YOU INVITE THE DISCUSSANT, DR KELLY MACDONALD)

To lead us into the discussion, I would like to invite Dr Kelly Macdonald.

Dr Macdonald is the Director of the HIV Research Program and Associate Professor of Medecine and Immunology at the University of Toronto. And in Nairobi, Kenya, Dr Macdonald supervises research labs where graduate students and post-doctoral fellows study the immunobiology and epidemiology of HIV infection…

Dr Macdonald…

(INTRODUCTION FOR DR BERNARD KOUCHNER AFTER THE SECOND PANEL's DISCUSSION)

Nous avons la chance de terminer ce forum avec le docteur Bernard Kouchner, qui a accepté de nous faire part de ses réflexions.

Né en France, il était l'un des six médecins de la première équipe médicale constituée par le Comité international de la Croix-Rouge en 1968 pendant la guerre du Biafra. L'expérience qu'il a vécue lors de cette guerre horrible qui a fait deux millions de morts a façonné sa vision des obligations du médecin. Non seulement croit-il que les médecins doivent parler des atrocités dont ils sont témoins, mais il estime en outre qu'ils ont un devoir d'ingérence en situation de guerre.

Au Biafra, le docteur Kouchner a créé un comité d'intervention d'urgence qui est ensuite devenu, en 1971, Médecins Sans Frontières. Il a quitté cette association humanitaire en 1979 pour fonder Médecins du Monde, en 1980. Au fil des ans, il a pris part à des missions en

Ouganda, au Liban, au Tchad, en Érythrée, au Soudan, en Afghanistan, au Salvador et dans d'autres pays en guerre.

En 1988, le docteur Kouchner s'est lancé en politique. Élu au gouvernement, il a occupé plusieurs postes, dont celui de ministre de la Santé en 1992 et 1993. Il est d'ailleurs revenu à la tête de ce ministère après la victoire de Lionel Jospin, en 1997.

En 1999, le Secrétaire général des Nations Unies l'a nommé haut commissaire chargé de l'administration civile au Kosovo. Il a quitté ce pays en janvier 2001.

Dans son action, le docteur Kouchner a toujours cherché à mettre ses principes en application et à contribuer au bien-être de l'humanité.

Je vous prie de bien vouloir accueillir très chaleureusement le docteur Bernard Kouchner…

(MAUREEN, FOLLOWING DR KOUCHNER'S PRESENTATION:

1. YOU CAN ALLOW A FEW QUESTIONS IF TIME PERMITS

2. RECALL THAT THERE WILL BE A WORKING SESSION FOR ALL INTERESTED PARTIES AT 2:30 PM IN THE SAME ROOM

3. AND INVITE THE PARTICIPANTS TO THE LUNCHEON OFFERED BY THE CONFERENCE OF MONTREAL).